WINCHESTER WOMEN'S
SPECIALISTS, P.C.

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Obstetrics • Gynecology • Infertility
Mammography & Laser Surgery
Colposcopy & Hysteroscopy
Diagnostic Laboratory

PATIENT REGISTRATION FORM

Date:_____ Doctor:_____ Chart#:_____

Patient Name:_____ Home Phone#( )_____
(Legal First) MI Last

P.O. Box:_____ Work Phone # ( )_____ Ext____

Street Address:_____ Cell Phone#( )_____

City:_____ State:___ Zip:_____ Date of Birth:_____ Age_____

Patient Employer:_____ Patient Occupation:_____

Employer Address:_____ Martial Status:_____

Social Security#:_____ Referring MD.:_____ Family M.D._____

Maiden Name:_____ Last Menstrual Period:_____

Medication Allergies? Yes ____ No ____ Hysterectomy: Yes___No___Date: _____

If Yes, What?_____

Preferred Pharmacy_____ _____ ___ _____
(not mail-in) Name Street Name City State ZIP

Emergency Contact:_____ Phone#:_____

Relationship to Patient:_____ Email: _____

Spouse's Name:_____ Spouse's SS#: _____
Spouse's DOB:_____

Spouse's Employer:_____

Spouse's Employer's Address:_____

INSURANCE INFORMATION:

Primary Ins. Co:_____ Name of Insured:_____

Group#_____ ID#_____ Date of Birth of Insured: _____

2nd INS CO:_____ Name of Insured:_____

Group#_____ ID#_____ Date of Birth of Insured:_____

PLEASE GIVE RECEPTIONIST A COPY OF YOUR INS. CARD

WINCHESTER WOMEN'S SPECIALISTS

FINANCIAL POLICY
2015

Thank you for choosing our Practice as your healthcare provider. We are committed to providing you with the highest quality of care. You should understand that timely payment of any bills is necessary. **Please review and sign below.**

- All co-pays and deductibles are due at the time of service. If you are uninsured, we expect full payment at the time of service. Payment plan options should be discussed with us prior to the date of service.

- We will ask that you update your individual information each time you are in the office so that we can ensure timely correct billing. Your signature below indicates your willingness for us to communicate with your insurance carrier for the purposes of verifying benefits and submitting insurance billing.

- If your insurance terminates while we are providing care, you will be responsible for all bills.

- We require that you give us 24 hour notice of appointment cancellation, or accept that we will charge you for a repeated history of missed appointments.

- Services performed outside of the practice are billed separately by the provider of these services. These services may include: certain lab testing, hospital facility charges, and mammography readings. We use BioReference Laboratory for lab tests we do not do here, who will send you a separate bill as necessary.

- There is a charge of $20 per disability form and/or FMLA form completed by our office. Payment is due when you give us the form. You should expect five (5) working days for completion of these forms.

- Our rates and services are usual and customary for our geographic area. We accept cash, personal checks, VISA, MASTERCARD and DISCOVER. There is a $50.00 fee for returned checks.

- Failure to pay your bill in a timely manner will result in our terminating our physician/patient relationship and we may transfer your account to an outside collection firm. Should we have to proceed with collection efforts, you will be responsible for any costs charged to us by our collection agents, attorneys and the Virginia Court System.

I have read this Financial Policy and agree to these terms.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINT NAME

_____ _____

GUARDIAN SIGNATURE DATE

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GYNECOLOGIC INTAKE HISTORY

NAME:_____ BIRTH DATE:___/___/____ DATE:___/___/____

ADDRESS:_____

CITY_____ STATE/ZIP:_____

HOME TEL:( )_____ WORK TEL:( )_____

EMPLOYER:_____ INSURANCE:_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. MUSCULOSKELETAL			
Muscle weakness	☐	☐	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

9. SKIN/BREAST	CURRENTLY	PAST	NOTES
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. PSYCHIATRIC			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	☐	☐	
Drugs, other	☐	☐	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS			
Reason	Date	Reason	Date

INJURIES/ILLNESSES			
Type	Date	Type	Date

LAST IMMUNIZATION OR TEST			
	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY			
	Number		Number
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits						
Smoking	Yes ☐	No ☐	Packs per day_____	Years_____		
Alcohol	Yes ☐	No ☐	Drinks per day_____	Drinks per week_____		
Drug Use	Yes ☐	No ☐				
Seat Belt Use	Yes ☐	No ☐				
Regular Exercise	Yes ☐	No ☐				

Personal Profile				
Marital Status	Married ☐	Single ☐	Widowed ☐	Divorced ☐
Number of Living Children_____				
Number of people in household_____				
School Completed	High School ☐	College ☐	Graduate Degree ☐	Other ☐
Current or most recent job_____				

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:_____

Date reviewed by physician with patient:_____

Physician Signature:_____

Annual Review of History

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____ Physician Signature:_____